

**House Government Reform Subcommittee on Criminal Justice, Drug Policy,
and Human Resources, U.S. House of Representatives**

**Hearing on "Harm Reduction or Harm Maintenance:
Is There Such a Thing As Safe Drug Abuse?"
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Respectfully submitted,

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INTRODUCTION

Chairman Souder, Co-Chair Cummings, and members of the Subcommittee. It is a privilege to submit testimony to the Committee about "harm reduction" as it relates to intravenous drug use and the related scourges of HIV-AIDS, hepatitis, crime, etc. The following testimony reflects my experience of the past 35 years as a physician deeply involved clinically, academically and administratively in addiction treatment, particularly with methadone and, more recently, buprenorphine maintenance treatments.

Allow me at the outset, however, to make certain acknowledgements that I believe are richly deserved and bear directly on the important issue being considered by the Committee. First, I acknowledge with the most sincere appreciation the efforts of Chairman Souder to remove the current inflexible limit of 30 patients that can be prescribed the medication Buprenorphine by any group of physicians, regardless how large and experienced. Buprenorphine has been hailed as an additional medicine that has utility in the treatment of addiction, and removal of the limit on patients served by groups is essential if it is to be made available to more of those who now have no treatment options. ***Treatment with Buprenorphine reduces the harm associated with narcotic addiction.***

Secondly, I note the public support that has been given by Co-Chair Cummings to the medication methadone, which has been utilized with great effectiveness for many hundreds of thousands of patients in America and throughout the world. This year marks the 40th anniversary of the pioneering studies by Drs. Marie Nyswander and Vincent Dole, introducing this remarkable treatment. The aim of methadone, like the aim of Buprenorphine, ***is the reduction of harm associated with narcotic addiction.***

And finally, I would like to mention the incredibly dedicated and effective work of the organization Mothers Against Drunk Driving (MADD) – an organization that also happens to celebrate in 2005 the anniversary of its founding, 25 years ago this coming September. No group demonstrates or practices more clearly the concept of harm reduction, or implements the concept with greater success; in a recent statement (Jan. 12, 2005) it was estimated that “the organization has helped save nearly 300,000 lives since its founding.” Bravo for MADD, and the phenomenal success it has achieved in reducing harm – tragic harm, on an enormous scale - associated with driving under the influence of alcohol!

Additionally, I would respectfully state in this introduction to my testimony today that “legalization” is totally distinct from “harm reduction.” One can zealously advocate and practice one and reject the other. I personally have argued consistently and emphatically, in countries throughout the world for over 35 years, that every possible means should be pursued to lessen the harm to addicts and the society at large, but I have never advocated legalization (indeed, I do not even know how to define the term). The same distinction between the two concepts is illustrated by MADD, which has forcefully and effectively fought for reducing the terrible consequences of drunk driving, but has – to my knowledge – never proposed that zero-tolerance to alcohol – i.e., prohibition - be reintroduced in America. Again, these are two very distinct issues.

It is my personal view, based on my long-term active involvement in this field, that addiction is a “chronic medical condition,” a rubric applied to a host of illnesses that are treatable, but (as of now) incurable. In the case of addiction, the ability to treat, and treat with great effectiveness, has been proven in countries throughout the world, including our own.

And finally, before proceeding with the substance of my testimony, I would like to answer the question posed by the subtitle of this Hearing: “Is there such a thing as safe drug abuse?” I will not equivocate in responding, and my response is an emphatic “No!” Nor are harm reduction efforts *intended* to make drug use “safe;” rather, they seek to lessen the extraordinary suffering, death and dissolution of families and communities with which addiction is associated. These goals are consistent with the fundamental canons of medicine that have guided the profession for millennia – and they are known, unequivocally, to be achievable in the case of addiction. Not to pursue them, to ignore the initiatives that have been shown consistently to improve and save lives, would be incomprehensible – and unconscionable.

BASIC CONCEPTS – AND MISCONCEPTIONS

In an area as complex as addiction, it is essential to recognize – and dispel – certain fundamental misconceptions. Thus, it is commonly (but erroneously) assumed that those who are addicted to illicit drugs are motivated primarily by hedonism – i.e., the desire to experience euphoria. In fact, however, many users (in my experience, the great majority) are driven not by the wish to “get high,” but by a physical “craving,” or need. This craving may be a result of repeated use of the substance, an inherent (i.e., inherited) predisposition for physical dependence, or – most likely – both.

The admittedly vague notion of a physical “craving” may sound like an attempt to put the drug user beyond reproach by suggesting lack of control over his/her behavior, thereby rejecting the assumption of personal responsibility. However, before dismissing the concept of craving as rationalization, consider that it is a painful, recurrent reality to countless *smokers* – but impossible to describe to those who have not experienced the overwhelming compulsion, at any time of day or night, in any weather, at any cost, to obtain cigarettes when the last pack is empty. It may also strike a more concordant note to consider the situation with regard to another addiction which is common in our society – addiction to alcohol. The very definition of alcoholism is a sobering reminder of the complexity of the problem with which we are concerned: “Alcoholism refers to a *chronic disease* in which the alcoholic craves and consumes ethanol without satiation. . . . [It] occurs in all socioeconomic classes and cultural groups [and] although environmental conditions influence drinking, *many individuals are at risk to develop alcoholism because of genetic factors*” (emphasis added).¹ Whatever constellation of etiological factors is at play, it seems unlikely that alcoholics drink in order to pursue feelings expressed in positive terms such as “euphoria” or “contentment.” Surely, no one who has seen an inebriate, unable to control voice, gait, judgment or excretory function, could imagine for a moment that *these* are the consequences of drinking sought by the alcoholic.

Related to the misconception that addicts are driven by hedonism is the widespread conviction that they lack motivation for treatment and can only be engaged under legal duress (i.e., under the threat of incarceration). Repeatedly over the past three and a half decades, in countries throughout the world, the motivation of addicts to seek and accept treatment on a voluntary basis

has been demonstrated. Thus, in the early 1970's in New York City, some 50,000 opiate-dependent individuals sought and received treatment in the various drug-free and chemotherapeutic modalities that were made available over a period of just a few years. In Hong Kong shortly thereafter, a network of over 20 methadone-dispensing clinics was established and from one year to the next almost 10,000 patients were admitted. In Australia in the late 1980's, and in Germany and France in the 1990's, many tens of thousands of heroin addicts entered treatment once it became available.

Nor is it true that addicts don't care about their health, and that of others with whom they have contact. Even among addicts who reject treatment and/or for whom treatment is not available, harm reduction initiatives are very widely utilized. This applies to bleach, condoms, needle and syringe exchange services, safer injection facilities, HIV testing and counseling, etc. Whatever the arguments might be for withholding such harm reduction services, they definitely do **not** include either lack of acceptance by the target population, or ineffectiveness in lowering morbidity and mortality, and slowing the spread of the human immunodeficiency virus.

EFFECTIVENESS: COMPARED TO WHAT?

A major hurdle in gaining endorsement of harm reduction services (including treatment) for addicts is the insistence on outcomes that are unrealistic and unreasonable. Once again, alcoholism is a relevant and revealing study in contrasts. Alcoholics Anonymous (AA) has for many decades been acclaimed throughout the world, and its twelve-step program is highly respected as a way to help those afflicted stop – or at least lessen – their consumption of alcohol. A popular slogan proclaims that “alcoholism is a treatable disease.” It is important to understand the disparity between near-universal **acceptance** of this underpinning of AA, and the equally widespread **rejection** of harm reduction and therapeutic approaches to other drug dependencies.

The reason for the diametrically different views would appear to rest in the disparate **expectations regarding outcomes** associated with the care afforded the respective conditions. In the case of alcoholism, the standard used to measure effectiveness, as expressed so succinctly and eloquently by AA, is “one day at a time.” It is acknowledged that today's “success” in achieving sobriety may well be followed by tomorrow's relapse; however, when relapse occurs (and more often than not it does), it does not denigrate in the slightest the value of the help that has been provided, nor lessen the zeal of service providers in encouraging drinkers to return to AA or another program of their choice. Furthermore, and equally critical, is the uncompromising conviction of AA devotees that ***the alcoholic can never, ever, be cured.***

This orientation to alcoholism, of course, mirrors precisely that which governs the treatment of the great majority of other medical conditions, both those that are primarily physical (diabetes, epilepsy, hypertension, arthritis, etc.), and those commonly labeled “mental” (e.g., schizophrenia and depression). In all these examples it is recognized, expected and accepted that the disease can be treated, often with great efficacy, even though cure is unattainable. The ever-present, generally life-long, possibility of recurrence and even progression of signs and symptoms is simply a frustrating reality and a therapeutic challenge, and **not** justification for nihilistic abandonment of those afflicted. “Cure” is not the aim in the management of any of these innumerable medical conditions, and it most certainly is not **demand**ed as a *sine qua non* of “effectiveness.” And yet, the pragmatism, realism and common sense evident with respect to

alcohol dependence and other chronic medical conditions are inexplicably lacking when the dependence involves substances that have been defined by legislative *fiat* as “illegal”.

The fact is that addiction – whether to alcohol, opiates or any other substance - is indeed a chronic medical condition like any other, and its treatment must be guided by similar objectives and parameters of effectiveness. Sadly, this is rarely the case. A striking illustration is “substitution treatment” (methadone in particular), whose extraordinary, worldwide success still tends to be dismissed with the comment, “Yes, but how many can be ‘cured’?” In essence, the utility of methadone is commonly measured by what happens after it is discontinued. Such an orientation would be unthinkable if applied to anti-hypertensive or anti-epileptic agents; or to insulin for the diabetic; or Levodopa – “the single most effective agent in the treatment of Parkinson’s disease”²; or anti-inflammatory medications prescribed for chronic arthritis; etc. etc. *ad infinitum*.

With regard to other forms of “harm reduction” – e.g., needle exchange – criticism also focuses on the undeniable limits of success; they do not **eliminate** drug addiction or its consequences, but they certainly do reduce – markedly – its terrible consequences. Their goal is to **lessen** risks associated with injection, and the extent to which this goal is achieved is a true blessing for the addicted and for the entire community.

In seeking to understand the unprecedented tendency to make “the best” the enemy of “the good” when it comes to assessing responses to addiction, it is easier to **exclude** explanations that seem, superficially, to bring logic to an otherwise incomprehensible deviation from the norm but on closer inspection do not hold water. Specifically, the explanation can **not** lie in the fact that addiction is a self-inflicted condition, since this is equally true of a host of other diseases to which physicians and the public at large respond supportively, with measures clearly acknowledged to be aimed at reducing rather than eliminating harm. To the extent the heroin addict is to be blamed for his/her addiction, the same criticism would have to be leveled at the alcoholic; and yet, those who drink to excess, whether from need or desire, usually elicit more sympathy than approbation. Furthermore, it is not only the alcoholic who escapes the contempt and hostility of society for “culpability” in causing the disease. The majority of insulin-dependent adult-onset diabetics could live healthy and medication-free lives **if** they controlled their diet, exercised, stopped drinking, reduced stress, etc. The same constellation of common-sense behaviors would eliminate (often without reliance on medication) signs and symptoms of hypertension and various cardiological conditions. And then, of course, there is the chronic smoker - who generally does not face the hostility of the medical community, nor encounter barriers to treatment of emphysema, heart disease, cancer or the many other sequelae of nicotine addiction; the smoker is also not reviled or ridiculed because s/he smokes brands with lower nicotine content, or takes “replacement nicotine” in the form of gum or skin patches, for the express purpose of harm reduction.

In fact, “harm reduction,” which has evoked so much controversy and outright damnation in the area of addiction, applies to – and governs – the approach to virtually all medical conditions that challenge physicians and society at large. Only very rarely is there a realistic hope of **eliminating** harm, or the conditions that cause it. The brutal truth is that in the last analysis, the

alternative to harm reduction is abandonment – a policy that is not only inhumane but also antithetical to the interests of the entire society.

THE DOCUMENTED IMPACT OF HARM REDUCTION: PERSONAL EXPERIENCE LEADING TO PERSONAL CONVICTION

I have been privileged to work in many different settings, and observe both the favorable outcome of a strong commitment to harm reduction, and the terrible consequences when harm reduction is rejected by Government decision makers. The massive increase in addiction treatment capacity in New York City in the early 1970's has been mentioned above. The result: a drastic reduction in crime, hepatitis and narcotic-related overdoses. Similarly in Hong Kong in the mid-1970's; there the immediate benefits (e.g., a 70% drop in drug-related arrests!), have been sustained and are today given credit for the fact that there is virtually no intravenous drug use related HIV-AIDS in that city (Hong Kong has publicized for 30 years the message: If you or a loved one have a problem with heroin addiction, immediate treatment is available). At the other extreme, sadly, we have the Russian Federation, which has rejected harm reduction from the outset and affords its estimated four million (!) addicts essentially no treatment options; the result: a massive epidemic of HIV-AIDS, tuberculosis and incarcerations in numbers exceeded only by America! America is in the middle of the spectrum: we've shown what can be accomplished in the early years of the decade of the 70s, but then expansion ceased and the availability of treatment actually dropped. Needle exchange and safer injection sites exist, but with no Federal support or endorsement. Some 80% of all intravenous heroin addicts have no access to treatment. And not surprisingly, our overwhelming focus on the criminal justice system to deal with the problem has caused more Americans to be behind bars than any other nation's population, and drug addiction remains the number one vector for the spreads of HIV-AIDS.

CONCLUSION

What goals should govern the response to addiction? The same as apply to any other chronic medical condition, for the simple reason that addiction *is* a chronic medical condition. From the standpoint of society as a whole, denial of harm reduction services is not only inhumane, but suicidal. We know unequivocally that harm due to drug addiction *can* be reduced, and with it crime, health problems, suffering and death – and also the burdens in financial and human terms, and in quality of life, for the entire society. We have an opportunity; the opportunity in turn represents a responsibility and obligation. Not to pursue it would be a very grave, unforgivable injustice to all Americans.

Thank you very much for the opportunity to share these views with your Committee.

REFERENCES

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2. *Goodman and Gilman The Pharmacological Basis of Therapeutics*, 9th edition. JG Hardman and LE Limbird, eds. In chief. McGraw-Hill; New York, 1996, p. 509.